



Manual and Recognition Program

Integrated Diabetes Education & Clinical Standards for American Indian & Alaska Native Communities

“A system to assure quality diabetes services for your community”

Indian Health Service National Diabetes Program

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Indian Health Service Integrated Diabetes Education and Clinical Standards Recognition Program

“The flexibility to assure quality diabetes services for your community”

Thank you for choosing the Indian Health Service (IHS) *Integrated Diabetes Education and Clinical Standards Recognition Program*. The IHS Recognition Program enables you to seek recognition of quality diabetes education and care services offered within your community. The IHS Recognition Program offers you flexibility in measuring your program success against nationally accepted standards.

The IHS recognition program allows you to build program success by using a three-stage approach:

Level 1 - Developmental

Completion of all elements at this level shows your community that your health services are starting work to develop a quality diabetes program.

Level 2 - Educational

Completion of all elements at this level shows your community that you provide quality diabetes education services.

Level 3 - Integrated Diabetes Program

Completion of all elements at this level shows your community that you provide quality diabetes education, clinical and public health services. Recognition at this level is the best you can be! It means that your facility offers the best in diabetes care and education practices. This includes community-wide prevention programs, diabetes clinical systems and educational programs for people with diabetes and their families.

This manual was developed to assist you in meeting your diabetes recognition needs. We use the National Standards for Diabetes Self-Management, May 2000, as the framework for the manual. Each of the ten standards is divided into three sections: developmental, educational and the integrated public health approach. Programs applying for the *IHS Diabetes Education Program Recognition* must meet the review criteria listed in the developmental (level 1) and educational (level 2) sections. Programs also have the choice to apply for the *IHS Integrated Diabetes Program Recognition* by meeting the review criteria elements at all levels.

Background

We developed the IHS Integrated Diabetes Education and Clinical Standards to allow flexibility for Indian health programs (IHS, tribal and urban) to show quality diabetes programming -- within the parameters of their health care infrastructure. IHS recognition will allow education programs that serve American Indian/Alaska Native communities to seek Medicare reimbursement.

Since 1984, the IHS National Diabetes program has endorsed the National Standards for Diabetes Education. In 1986, a task force of representatives from Indian health diabetes programs identified review criteria to guide diabetes program development and recognition within American Indian and Alaska Native communities. Besides the National Standards for Diabetes Education, the IHS National Diabetes Program task force included the IHS Standards of Care for Patients with Type 2 Diabetes. Review criteria included factors effective for quality diabetes programs within tribal communities. Thus, the *Integrated Diabetes Education and Care Standards Recognition Program for American Indian and Alaska Native Communities* was developed.

The IHS National Diabetes Program task force reconvened in the fall of 2000 to revise the IHS Integrated Diabetes Education and Care Standards and Recognition Program. The updated program reflects the most current National Standards for Diabetes Self-Management Education (May 2000). We continue to integrate the IHS Standards of Care for Patients with Type 2 Diabetes (March 2001) and other factors effective for quality diabetes programs within tribal communities.

The IHS Recognition Program enables you to seek recognition for quality diabetes care and education services in a way that best suits your community needs. Programs applying for Educational Recognition must meet the review criteria listed in the developmental (level 1) and educational (level 2) sections. Programs also have the choice to apply for the Integrated Diabetes Program Recognition (level 3) by meeting the review criteria elements at all three levels.

How to Use This Manual

We have developed a three-stage approach that provides Indian health diabetes teams some flexibility in planning for program recognition. The manual is organized by sections:

Section one (pages 3-4) contains the introduction and background.

Section two (pages 6-18) contains each of the ten standards and review criteria. You will see that review elements for each standard are divided into three levels: developmental, educational and the integrated public health approach.

Developmental

The review elements at this level provide your program with a framework to build the infrastructure and capacity necessary to sustain a quality diabetes program.

Educational

The review elements at this level continue to help your program identify the structure, process and outcome indicators that point to a quality diabetes self-management education program.
Programs completing the developmental and education levels can apply for IHS Diabetes Education Program Recognition.

Integrated Diabetes Program

Completion of all elements at this level shows your community that your facility provides quality diabetes education, clinical services and public health practices. Completing all of the elements at this level means you provide exceptional diabetes education and care to the community.

Programs completing all three levels can apply for IHS Integrated Diabetes Program Recognition.

Section three (pages __-__) contains a checklist, with each standard and review elements listed by level (developmental, educational, public health). You may want to use this checklist to “rate” your program and identify gaps.

Section four (page 19) contains definitions and terms used in the manual.

Section five (pages 20-) contains other resources that may help in your program development.

Section six (pages __-__) contains program recognition application instructions and forms.



Standard 1

The ITU diabetes self- management education entity documents an organizational structure, mission statement and goals, and will recognize and support quality diabetes self-management education as an integral component of diabetes care.

Standard One -- Review Criteria

Level 1 -- Developmental

Team

A diabetes team structure and process are identified (composition of team, meeting place/time/frequency, roles/responsibilities, etc). At a minimum, the team shall consist of a primary care provider (MD, DO, NP, PA), registered nurse and registered dietitian. Other appropriate staff may be members of the team (pharmacist, health educator, mental health, medical technologist, public health nurse, community health representative, community members, health board members, etc.). Emphasis at this stage is the education component.

Registry

A registry of all people served by the program (entity) with diabetes is in place. Registry information shall follow standard data guidelines suggested by the IHS National Diabetes Program and IHS Area Diabetes Consultant. Registry documentation should include the process used for annual updates. See pages 22-23 for Area Diabetes Consultant (ADC) listing. Your ADC can help you with your registry assessment.

Organizational Chart

Discussions begin to place the diabetes program within the appropriate administrative organizational structure.

Program Manual

A program manual is being developed which includes an overall program description, policies, mission statement, goals, annual plan, organizational chart, team member roles and responsibilities, education program structure, forms etc. The manual will also include the following supporting documents:

- Team Commitment -- A written statement that affirms the use of a team to deliver diabetes self-management education.
- Administrative Commitment -- A written statement signed by an appropriate official(s), which affirms diabetes self-management education as an integral component of diabetes care.
- Tribal Commitment -- A written statement affirming the tribe's commitment to diabetes self-management education. Statement can be in the form of a letter, tribal resolution or found in the mission statement.



Standard 1

The ITU diabetes self- management education entity documents an organizational structure, mission statement and goals, and will recognize and support quality diabetes self-management education as an integral component of diabetes care.

Standard One -- Review Criteria (cont.)

Level 2 -- Educational

Team

Meetings are documented and conducted on a scheduled basis. Monthly meetings are encouraged; at a minimum, meetings occur on a quarterly basis. Minutes shall document evidence of:

- role definition and responsibilities,
- communication among team members regarding program policies and goals and other educational issues,
- coordination/consistent approach to interpreting diabetes concepts,
- coordination between appropriate departments.

Registry

There is evidence that the diabetes registry is updated annually. There is evidence that the diabetes education team assesses the registry and uses information for annual planning.

Organizational Chart

The diabetes education program is recognized in the organizational structure of the facility. The line of authority for the diabetes education program team and/or staff is identified.

Program Manual

Program manual complete (contains all necessary documentation supporting educational program, including organizational structure, mission statement, goals, annual plan, description of educational team and educational process, follow-up and other program components). Approval mechanisms for both policy and program changes are clearly defined. There is evidence that the program manual is reviewed annually and signed by appropriate individuals.



Standard 1

The ITU diabetes self-management education entity documents an organizational structure, mission statement and goals, and will recognize and support quality diabetes self-management education as an integral component of diabetes care.

Standard One -- Review Criteria (cont.)

Level 3 -- Integrated Public Health Approach

Team

Team membership includes clinical, education, public health and community representatives (as appropriate to the facility). Team minutes reflect a coordinated approach to diabetes management and education. There is evidence of the integration of diabetes education and medical standards.

Registry Evidence

General diabetes registry, complication and other registries appropriate for the community (impaired glucose tolerance, gestational, ESRD, hypertension, etc.) are in place and updated annually.

Organizational Chart

The diabetes program is recognized in the organizational structure of the facility.

Program Manual

The program manual describes education, and clinical and public health components for diabetes prevention and management. The manual also includes documentation of:

- Team commitment. The National Standards for Diabetes Self-Management Education (May 2000) and the IHS Standards of Care for Patients with Type 2 Diabetes (March 2001) are endorsed by all team members.
- Administrative commitment. The National Standards for Diabetes Self-Management Education (May 2000) and the IHS Standards of Care for Patients with Type 2 Diabetes (March 2001) are endorsed by the appropriate health care administration.
- Tribal commitment. There is a written statement in place affirming the tribe's commitment to address diabetes prevention and management (e.g., resolution, letter from tribal administration).



Standard 2

The Indian health diabetes education entity will determine its target population, assess educational needs, and identify the resources necessary to meet the self-management educational needs of the target population.

Standard 2 -- Review Criteria

Level 1 -- Developmental

Education Program

Tasks that need to be accomplished in order to develop an education program are identified and outlined.

Assessment

The program describes its target population (newly diagnosed, gestational, elders, youth, etc.), documents assessment activities, describes educational needs of target population(s) and identifies program goals and objectives.

Resource Requirements

The program identifies the space, staffing, budget, instructional materials, staff education and other resources needed to develop and maintain the diabetes education program. There is evidence of an assessment process to identify education resources and interventions known to be successful for American Indian/Alaska Native communities.

Level 2 -- Educational

Annual Goals and Objectives

There is evidence of annual program goals and objectives which are realistic, measurable and consistent with the needs of the population served. Team meeting agendas/minutes reflect tracking and progress towards annual goals/objectives. Resources are provided to meet identified goals and objectives.

Target Population

There is evidence that diabetes self-management services meet the needs of the target population. Evidence can include team minutes, population assessments, community surveys, marketing brochures and other related materials.

Resource Requirements

There is evidence of ongoing resource assessment as programs expand to meet community needs.

Access to Care

There is evidence that the Indian health diabetes education entity defines how a consumer gains access to care. Evidence can include documentation in team minutes and/or program manual. Documentation should include a short description of community access challenges/barriers and methods or strategies used to improve access.



Standard 2

The Indian health diabetes education entity will determine its target population, assess educational needs, and identify the resources necessary to meet the self-management educational needs of the target population.

Standard 2 -- Review Criteria (cont.)

Level 3 -- Integrated Public Health Approach

Diabetes prevention and control services are considered at three levels:

- Primary Level: The maintenance of health by removal of precipitating causes and determinants of departures from good health.
- Secondary Level: The early detection of disease before it has time to progress and cause irreversible damage.
- Tertiary Level: Preventing deterioration and complications from occurring when disease or disability are already established.

Annual Goals and Objectives

Community assessment information is expanded and utilized for annual planning. Diabetes team develops goals and objectives based on assessment information. Methods shall include use of information (community profiles, surveys, diabetes audit data, complications, etc.) obtained from various assessment activities (tribal administration services, clinical or other public health approaches). There is evidence of community-based and clinical diabetes prevention programs.

Target Population

There is evidence that diabetes self-management services meet the needs of the target population. Evidence can include team minutes, population assessments, registry analysis, etc.

Resource Requirements

There is evidence of ongoing resource assessment as the program expands to meet community needs.

Access

The program defines how a community member gains access to the education and clinical services (referral, self-referral, etc.). Community access issues for both educational programs and clinical services are further defined and documented. Marketing strategies are developed to help increase access to educational and clinical services.

Community Prevention

There is evidence of community-based prevention activities to promote healthy life-styles (examples: school health, elder programs, community group education, community healthy cooking classes, etc.).

Clinical Care

There is a system in place for maintaining continuity of care. This includes a mechanism to identify cases lost to medical and educational follow-up. The utilization of follow-up services is tracked.



Standard 3

An established system (committee, governing board, advisory board) involving professional staff and stakeholders will participate annually in a planning and review process that includes data analysis and outcome measurements, and addresses community concerns.

Standard 3 -- Review Criteria

Level 1 -- Developmental

Advisory Body

Program identifies advisory body(s) and documents communication. Advisory body (s) reflects community served. Examples of an advisory body are Tribal Health Board, Governing Body, Tribal Council, Wellness Committee; or, programs may create a new advisory system. Members should represent both medical/educational and community/consumer groups. Multiple advisory bodies are acceptable, based on established systems within communities (i.e. issues regarding diabetes education with seniors may be addressed by both Tribal Health Board and Elder Committee, issues with school health may be addressed by school board and/or Tribal Council.) Minutes should reflect advisory body selection, approaches/methods used to seek advice and outcomes.

Level 2 -- Educational

Advisory Body

There is a process that provides community and other advisory member input to the education program, including curriculum and annual program plan, at regular intervals, but at least annually.

Level 3 -- Integrated Public Health Approach

Advisory Body

The advisory body(s) has the opportunity to review and comment on diabetes programs including curriculum, annual program plan and audit results. There is evidence that policy recommendations have been forwarded to the administrative unit for approval and signatures.



Standard 4

The Indian health diabetes education entity will designate a coordinator with academic and/or experiential preparation in program management and the care of individuals with chronic disease.

The coordinator will oversee the planning, implementation and evaluation of the Indian health diabetes education entity.

Standard 4 -- Review Criteria

Level 1 -- Developmental

Coordinator

A coordinator is identified. The coordinator is a credentialed health professional with appropriate education and experience. The coordinator's responsibilities and line of authority are defined. Documentation of coordinator's credentials, roles and responsibilities, and line of authority is found in the program manual.

Level 2 -- Educational

Coordinator

The coordinator manages the following team efforts:

- development of goals and objectives,
- planning and implementation of program activities,
- evaluation of program content and outcome.

The coordinator acts as the diabetes education liaison between team members, departments or programs and the community. The responsibilities shall be reflected in the position description and employee performance appraisal system (urban, tribal or IHS). The coordinator documents a minimum of twelve (12) hours every two years of continuing education in diabetes, educational principles or leadership/management. CEU content and distribution of hours should be based on professional discretion.

Level 3 -- Integrated Public Health Approach

Coordinator

The coordinator acts as a liaison between multi-disciplinary team, programs and departments providing comprehensive services for individuals with diabetes and their families. The coordinator manages the diabetes education program and is a leader or team member in clinical and/or community diabetes programming. Coordinator leads or helps organize diabetes chart audits and surveillance systems (prevalence, complications, etc), coordination of consumer care services, orientation of clinical staff, field health, tribal and other personnel to diabetes programs, and program budget preparations.



Standard 5

The Indian health diabetes education entity will involve the interaction of the individual with diabetes with a multifaceted instructional team, which may include a behaviorist, exercise physiologist, ophthalmologist, optometrist, pharmacist, physician, podiatrist, registered dietitian, registered nurse, other health care professionals and para-professionals.

The instructional team is collectively qualified to teach the content areas. The instructional team must consist of at least a registered dietitian and a registered nurse. At least one of the instructional staff must be Certified Diabetes Educators (CDE), OR have recent didactic and experiential preparation in education and diabetes management.

Standard 5 -- Review Criteria

Level 1 – Developmental

Instructors

Diabetes program team members with knowledge and skill in diabetes education are identified and appointed as the instructional team. The program manual will include listing of instructional staff, credentials, roles and responsibilities. Indian health instructional teams must include a registered nurse and a registered dietitian. Facilities, with documented justification, may include off-site professional staff / consultants (local contract, Area Consultants, Model Diabetes Program staff, etc.) as instructional team members. Their role and responsibility on the instructional team is based on community needs and documented in team minutes or in the program manual. Indian health diabetes education entities must have at least one RN or RD staff available for direct one-on-one or group education services.

Level 2 – Educational

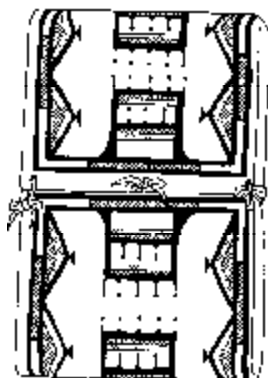
Instructors

Instructors provide educational program services for the target population. Instructors use a variety of teaching learning methods to meet the needs of the individual, family and community, and evidence of this will be included in education program agendas and curricula outlines. There is evidence that the team advocates a consistent and coordinated approach to present basic diabetes concepts. This approach is promoted by review of education materials, teaching methods and activities.

Level 3 – Integrated Public Health Approach

Diabetes Team

Instructional team is able to provide multifaceted level of diabetes education that includes integration of traditional and western methods of teaching/learning activities. Components can include talking circles, youth prevention groups, case management, elder teaching, increased use of paraprofessional and other strategies appropriate within community and cultural systems.



Standard 6

The Indian health education entity instructors will obtain regular continuing education in the areas of diabetes management, behavioral interventions, teaching and learning skills, and counseling skills.

Standard 6 -- Review Criteria

Level 1 -- Developmental

Instructors

There is evidence that instructors are familiar with diabetes and its management in American Indian/Alaska Native populations and have the knowledge, skills and abilities in behavioral interventions, teaching/learning and counseling/communication methods.

Level 2 -- Educational

Instructors

There is evidence that instructors maintain a minimum of twelve (12) continuing education hours every two years in diabetes management, behavioral interventions, teaching and learning skills, and counseling skills. CEU choice shall be based on instructor need. CEU content and distribution of hours should be based on professional discretion.

Level 3 -- Integrated Public Health Approach

Diabetes Team

There is evidence that diabetes team members participate in yearly diabetes management, behavioral interventions, teaching and learning skills, and counseling skills workshops and in-service programs relevant to diabetes in American Indians /Alaska Natives.



Standard 7

A written curriculum, with criteria for successful learning outcomes, shall be available. Assessed needs of the individual will determine which content areas are delivered.

Standard 7 -- Review Criteria

Level 1 -- Developmental

Curricula

Available diabetes education curricula are identified and reviewed. There is evidence that the accepted curricula is reviewed and modified to fit community needs. Curricula will include written and measurable learning objectives, a content outline, instructional methods, materials, and means of evaluating the achievement of objectives. Content will include:

- Describing the diabetes disease process and treatment options
- Incorporating appropriate nutritional management
- Incorporating physical activity into life-style
- Utilizing medications (if applicable) for therapeutic effectiveness
- Monitoring blood sugar, urine ketones(if applicable), and using the results to improve control
- Preventing, detecting, and treating acute complications
- Preventing (through risk reduction behavior), detecting, and treating chronic complications
- Goal setting to promote health, and problem solving for daily living
- Integrating psychosocial adjustment to daily life
- Promoting preconception care, management during pregnancy, and gestational diabetes management (if applicable)

Level 2 -- Educational

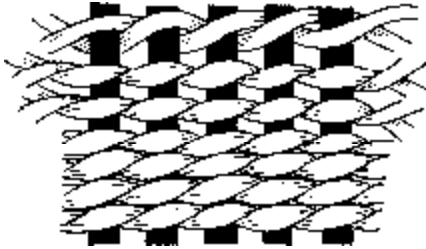
Curricula

The curricula and other education program resources/materials are reviewed annually by instructors for scientific accuracy and cultural relevancy. New materials used in the education program are field tested for relevance and comprehension. Interpreters (if used) are oriented on an established basis.

Level 3 -- Integrated Public Health Approach

Curricula

There is evidence of medical, public health staff and community participation in curricula review and adaptation. Evidence can include medical staff minutes, memos or integration of diabetes care and outcomes audit analysis. Community input can be documented with consumer feedback, focus groups, field testing, survey or other methods.



Standard 8

An individualized assessment, development of an educational plan, and periodic reassessment between participant and instructor(s) will direct the selection of appropriate educational materials and interventions.

Standard 8 -- Review Criteria

Level 1 -- Developmental

Assessment Form

Instructional team develops an individualized educational needs assessment process and form for documentation. Indian health facilities may use a standard IHS form, formatted PCC form or approved medical record form. All forms must include information on relevant medical history, cultural influences, health beliefs and attitudes, diabetes knowledge/skill, readiness to learn, preferred learning methods, barriers to learning, family support and financial limitations.

Level 2 -- Educational

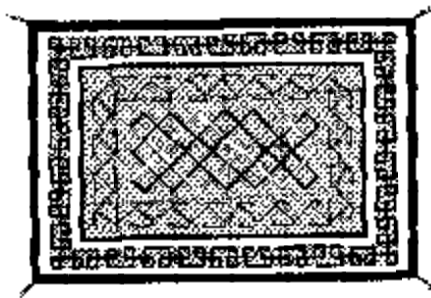
Educational Assessment

Instructional team adopts a standard diabetes education assessment process and documentation form. This completed form is used as the tool to guide the individual educational process, which includes an initial and ongoing educational plan. Educational assessment is done on an individual basis. Instructor develops learning objectives and educational plan with the client. Client identifies behavioral objectives with guidance from instructional team. Instructional team uses educational assessment as a basis of all educational plans, interventions and material selection. Instructional team documents periodic reassessment of individuals in caseload.

Level 3 -- Integrated Public Health Approach

Coordinated Diabetes Care and Education

The multidisciplinary diabetes care and education team uses a case management or other organizational diabetes best practice systems which coordinates the ongoing diabetes care and education needs of individuals on a consistent basis.



Standard 9

There shall be documentation of the individual's assessment, education plan, intervention, evaluation, and follow-up in the permanent, confidential education record.

Documentation also will provide evidence of collaboration among instructional staff, providers, and referral sources.

Standard 9 -- Review Criteria

Level 1 -- Developmental

Documentation Systems

Educational documentation methods (PCC, RPMS) and other educational forms are reviewed and modified for program use. There is evidence that instructional staff are familiar with education codes (RPMS preferred). SOAP charting is the accepted documentation method for educational interventions. There is a process defined in the policy and procedure manual regarding transfer of confidential medical record information.

Level 2 -- Educational

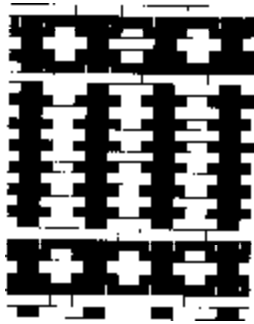
Medical Record

There is evidence of documentation of the teaching process including assessment, planning, implementation, and evaluation of the individualized educational experience. All information about an individual's diabetes education contacts will be maintained in the medical record. Medical record documentation shows evidence of collaboration among educational team, providers and other diabetes personnel. Educational codes are used in facilities with RPMS. Documentation can include case management reviews, referrals and referral summaries, follow up notices, plan of education or care, etc.

Level 3 -- Integrated Public Health Approach

Medical Record

All information about an individual's diabetes education and clinical care will be maintained in the medical record. All team members receive orientation and updates to diabetes documentation and coding issues within facility. Documentation includes community services.



Standard 10

The Indian health diabetes education entity will utilize a continuous quality improvement process to evaluate the effectiveness of the education experience provided, and determine opportunities for improvement.

Standard 10 -- Review Criteria

Level 1 -- Developmental

Evaluation

There is documentation of education program goals and objectives. Proposed evaluation design will include both behavioral and clinical indicators.

Consumer Satisfaction

Mechanisms for evaluating consumer satisfaction of educational services are evident.

Level 2 -- Educational

Evaluation

There is documentation of education program impact and outcome evaluation data which measures progress in achieving education program goals and objectives. Documentation includes:

- Input from diabetes team, health care providers and consumers,
- Program records documenting population served, types of services (individual/group, initial/continuing/follow-up), length of participation, setting, content (PCC codes), age categories, etc.
- Evaluation process used for a minimum of one(1) behavioral and two(2) clinical indicators,
- Modifications made or action taken as a result of program evaluation and consumer feedback

Level 3 -- Integrated Public Health Approach

Diabetes Care and Outcomes Audit

There is evidence that a diabetes care and outcomes audit is conducted annually. Specific educational indicators are included in the diabetes care and outcomes measures. Educational indicators are modified or expanded annually within the facilities capabilities.

Diabetes Prevention Programs

There is evidence that community diabetes prevention programs have an annual program evaluation or surveillance component in place.

Evaluation Results

There is evidence that continuous quality improvement data are shared with established advisory body, appropriate tribal leaders, community systems promoting diabetes prevention, and the tribal community. The results of these evaluations shall be used in subsequent planning and program modification.

Definition of Terms

Advisory Body - A method that seeks guidance and counsel from community representatives, health care administrators and professionals re: diabetes education, clinical and public health programs within the community.

Annual plan - Documentation that describes program goals, objectives, implementation process and methods, resource requirements/budget, consumer access and evaluation methods. Diabetes team uses the annual plan to monitor activities and outcomes

Behavioral objective - Medical record documentation of a patient identified behavior that he/she is willing to change. The individual behavioral objective should be realistic and measurable.

CEU - Continuing education unit. Documented in hours of continuing education activity. Includes CEU from accredited organizations and certificates of attendance at diabetes related inservices, regional meetings, etc. It is expected that professional staff will document majority of accredited CEU. Paraprofessional staff may have greater mix of accredited and non-accredited CEU.

Community - The social, cultural, political and geographic environment within which the Indian health facility offers services.

Consistent - Diabetes team members use the same terms, materials and descriptors when educating the community, individuals or families; "everyone is getting the same message."

Consumer access - A policy and process used to instruct providers, individuals and families about how to receive education, clinical or public health services.

Coordinated - Diabetes team works together in program planning, implementation and evaluation.

Educational plan - Medical record documentation of individual assessment, learning and behavioral objectives and evaluation. SOAP format preferred.

Goal - A statement that defines program aim or purpose.

IHS Diabetes Care and Outcomes Audit - A diabetes care surveillance system that tracks performance on more than 87 indicators to study trends over time. The system is based on IHS Standards of Diabetes Care (pgs 28-33) updated every two years. Information and directions for incorporating this system can be found at: www.ihs.gov/medicalprograms/diabetes.

Instructional material - Any material used in educational programming including pamphlets, audio-visual, models, etc.

Individualized educational assessment - The process used to identify learning needs with an individual; includes relevant medical history, diabetes history, risk factors, cultural influences, health beliefs and attitudes, barriers to learning, health behavior goals, support systems and other socioeconomic factors. Most information should be gathered during an interactive interview with the diabetes educator

Instructors - Health care professionals with knowledge, experience and demonstrated skill in diabetes self-management education process within AI/AN communities.

Integrated Indian Health Diabetes Education

Program - A quality diabetes education program that meets the National Standards for Diabetes Self

Management Education. The program operates within American Indian or Alaska Native communities and provides integration of diabetes education standards within community system.

Integrated Public Health Approach - Indian health diabetes program that offers quality diabetes education, clinical and public health services to consumers.

Learning objective - Medical record documentation of diabetes education aim and purpose based on individual assessment.

Objective - A statement that defines how programs will achieve the aim or purpose.

Periodic assessment - A set period for evaluation of program services.

Program manual - Documentation that describes policies, procedures and other facility systems created to enhance diabetes education, clinical care and public health services within the community.

Resources - Materials, systems, professional, consultation, technical or public health services available in community to enhance, support or assist diabetes self-management.

Stakeholders - Community members, individuals and families eligible for diabetes education, clinical or public health services.

Surveillance - Data obtained within a set period (quarterly, annually, weekly, etc).

Target population - That group of individuals and families who have the characteristics that the diabetes program defines as program participants (elders, youth, people with neuropathy, etc).

IHS Diabetes Centers/Model Programs

Alaska Diabetes Program

Ann Marie Mayer, Coordinator
Alaska Native Medical Center - Diabetes
4315 Diplomacy Drive
Anchorage, Alaska 99508
Phone: (907) 729-1125
FAX: (907) 729-1129

Albuquerque Diabetes Program

Elizabeth Toman, Co- Coordinator
Lani Desaulniers, Co-Coordinator
PHS Indian Hospital
801 Vassar Drive, NE
Albuquerque, New Mexico 87106
Phone: (505) 248-4017
FAX: (505) 248-7697

Blackfeet Diabetes Program

Debbie Powell-Taylor, Coordinator
Blackfeet Community Hospital
P.O. Box 760
Browning, Montana 59417
Phone: (406) 338-6305
FAX: (406) 338-6195 FAX: (505) 248-7697

Claremore Diabetes Program

Eileen Wall, Coordinator
PHS Indian Hospital
Claremore, OK 74017
Phone: (918) 342-6451
FAX: (918) 342-6585

Fort Berthold Diabetes Program

Celeste Hart, Actg. Coordinator
Fort Berthold DM Program
Minni-Tohe Health Center
New Town, North Dakota 58763
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FAX: (701) 627-4318

Ft. Totten Diabetes Program

Karen Frolich, Coordinator
PHS Indian Health Center
P.O. Box 309
Fort Totten, North Dakota 58335
Phone: (701) 766-1618
FAX: (701) 766-1620

Gila River Diabetes Education Center

Sheila Tann, Coordinator
Hu Hu Kam Memorial Hospital
P.O. Box 38
Sacaton, Arizona 85247
Phone: (520) 562-3321 ext. 1553
FAX: (602) 528-1245

Houlton Band of Maliseet Indians Diabetes Program

Simone Carter, Coordinator
Health Department
RR 3, Box 460
Houlton, Maine 04730-9514
Phone: (207) 532-2240
FAX: (207) 532-2402

Journey into Wellness Center Diabetes Program

Coordinator
Uintah & Ouray Service Unit
P.O. Box 160
Ft. Duchesne, Utah 84026
Phone: (435) 722-2456
FAX: (435) 722-4122

Lawton Diabetes Program

JoAnn Holland, Coordinator
PHS Indian Health Center
Lawton, OK 73501
Phone: (580) 353-0350 Ext. 560
FAX: (580) 353-3039 or 353-0350—206

Mississippi Band of Choctaw Indians Diabetes Program

Lynda Johnson, Coordinator
Choctaw Health Center
Route 7, Box R-50
Philadelphia, MS 39350
Phone: (601) 656-2211
FAX: (601) 656-5091

Navajo Area Diabetes Center at Shiprock

Martia Glass, Coordinator
Northern Navajo Medical Center
P.O. Box 160
Shiprock, New Mexico 87420
Phone: (505) 368-7425
FAX: (505) 368-7426/6260

IHS Diabetes Centers/Model Programs (continued)

Northern Minnesota Diabetes Resource Center

VACANT, Coordinator
PHS Indian Hospital
Rt. 3, Box 211
Cass Lake, Minnesota 56633
Phone: (218) 335-3245
FAX: (218) 335-2601

Omaha Tribe of Nebraska Diabetes Program

Craig Capron, Acting Coordinator
Carl T. Curtis Health Education Center
P.O. Box 250
Macy, NE 68039
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Revised National Standards for Diabetes Self-Management Education -- May 2001

Problem Statement

Diabetes Self-Management Education (DSME) is the cornerstone of care for all persons with diabetes who want to achieve successful health related outcomes. The National Standards for DSME are designed to define quality diabetes self-management education that can be implemented in diverse settings and will facilitate improvement in health care outcomes. The dynamic health care process obligates the diabetes community to periodically review and revise these Standards to reflect advances in scientific knowledge and health care.

Therefore, the Task Force to review the National Standards for DSME was convened to review the current Standards for their appropriateness, relevancy, and scientific basis, and to be sure they are specific and achievable in multiple settings. Task Force Organizations, Federal Agencies, and Federally Funded Programs included:

- American Diabetes Association
- American Association of Diabetes Educators
- The American Dietetic Association
- Veteran's Health Administration
- Centers for Disease Control and Prevention
- Indian Health Service
- National Certification Board for Diabetes Educators
- Juvenile Diabetes Foundation International
- Diabetes Research and Training Centers

The following is a listing of each standard by category.

Structure

Standard 1

The DSME entity will have documentation of its organizational structure, mission statement and goals, and will recognize and support quality diabetes self-management education as an integral component of diabetes care.

Standard 2

The DSME entity will determine its target population, assess educational needs, and identify the resources necessary to meet the self-management educational needs of the target population(s).

Standard 3

An established system (committee, governing board, advisory body) involving professional staff and other stakeholders will participate annually in a planning and review process that includes data analysis and outcome measurements, and addresses community concerns.

Standard 4

The DSME entity will designate a coordinator with academic and/or experiential preparation in program management and the care of persons with chronic disease. The coordinator will oversee the planning, implementation and evaluation of the DSME entity.

Standard 5

DSME will involve the interaction of the individual with diabetes with a multifaceted education instructional team, which may include a behaviorist, exercise physiologist, ophthalmologist, optometrist, pharmacist, physician, podiatrist, registered dietitian, registered nurse, other health care professionals and paraprofessionals. DSME instructors are collectively qualified to teach the content areas. The instructional team must consist of at least a registered dietitian and a registered nurse. Instructional staff must be Certified Diabetes Educators (CDE), or have recent didactic and experiential preparation in education and diabetes management.

Revised National Standards for Diabetes Self-Management Education (continued)

Standard 6

The DSME instructors will obtain regular continuing education in the areas of diabetes management, behavioral interventions, teaching and learning skills, and counseling skills.

Standard 7

A written curriculum, with criteria for successful learning outcomes, shall be available. Assessed needs of the individual will determine which content areas listed below are delivered. Content will include:

- Describing the Diabetes Disease Process and treatment options
- Incorporating appropriate Nutritional Management
- Incorporating Physical Activity into lifestyle
- Utilizing Medications (if applicable) for therapeutic effectiveness
- Monitoring blood glucose, urine ketones (when appropriate), and using the results to improve control

- Preventing, detecting, and treating Acute Complications

- Preventing (through Risk Reduction behavior), detecting, and treating Chronic Complications

- Goal Setting to promote health, and Problem Solving for daily living

- Integrating Psychosocial Adjustment to daily life

- Promoting Preconception Care, management during Pregnancy, and Gestational Diabetes Management (if applicable)

Process

Standard 8

An individualized assessment, development of an education plan, and periodic reassessment between participant and instructor(s) will direct the selection of appropriate educational materials and interventions.

Standard 9

There shall be documentation of the individual's assessment, education plan, intervention, evaluation, and follow-up in the permanent, confidential education record. Documentation also will provide evidence of collaboration among instructional staff, providers, and referral sources.

Outcome

Standard 10

The DSME entity will use a continuous quality improvement process to evaluate the effectiveness of the education experience provided, and determine opportunities for improvement.

IHS Standards of Care for Patients with Type 2 Diabetes -- May 2001

The Standards of Care for Type 2 diabetes have been developed and updated by the IHS National Diabetes Program to help provide consistent, quality care to patients with diabetes.

1 -- Baseline Studies

Height - Measure once and record on PCC Health Summary. If PCC is not available, record on diabetes flowsheet. For children <18 years of age, height and weight should be recorded at each visit. Use to calculate body mass index and ideal or reasonable body weight.

Date of Diabetes Diagnosis - Record on PCC Health Summary. If PCC is not available, record on diabetes flowsheet. Longer duration of diabetes correlates with increased risk of complications.

ECG - Obtain baseline then repeat every 1-5 years as clinically indicated (for those age 40 and above, or with diabetes duration over 10 years, every 1-2 years is recommended).

PPD - Should be documented once after diagnosis of diabetes. (Offer INH prophylaxis to patients according to protocol – refer to Section 9).

2 -- Each Clinic Visit

Blood Pressure - Target BP is $\leq 130/80$. Additional protection against complications, including renal failure, may be obtained by lowering BP further.

Weight - Compare with measurements from prior visits to identify trends.

Blood Glucose - Results of lab determinations and self-monitoring should be available for timely discussion with the patient. Hemoglobin A1c (HbA1c) at 3-4 month intervals.

- Fasting/casual glucose measurement and self monitoring records should be available for timely discussion with the patient at each visit. Self-monitoring BG records are vital to diabetes management decisions.

- Determine if **HbA1c** has been performed within the past 3-4 months, and order if due.

- Patients in acceptable glycemic control (HbA1c $\leq 7.0\%$) should be tested at least every 6 months. HbA1c estimates the average degree of glycemic control over the preceding 3 months. HbA1c is the standard way to measure glycemic control.

- HbA1c results should be discussed with the patient at the time of the patient visit. If in-house measurement is unavailable, blood sample should be obtained several days before the clinic visit. At each clinic visit, the appropriate education, intervention, referral, and or follow-up will be provided as indicated.

Foot Check - Inspection of feet and nails. Check for ingrown toenails, calluses, deformities, pressure points, ulcers, and cellulitis.

IHS Standards of Care for Patients with Type 2 Diabetes (continued)

3 -- Annual

Creatinine - Screen for renal insufficiency.

Complete UA/Microalbuminuria - A test for urine protein should be performed yearly. If negative, a screening test for microalbuminuria should be performed (by A/C ratio or dipstick test). Dipstick-positive microalbuminuria should be confirmed on a separate specimen using an A/C ratio (abnormal $\geq 30\text{mg/gm}$) or 24 hour urine. ACE inhibitors should be considered in patients with microalbuminuria or proteinuria, even if normotensive.

Lipid Profile

Risk factors for atherosclerosis include LDL >100 , HDL <40 in men and <45 in women, and TG >200 . Even lower LDL and TG values represent increased risk in persons with previously documented atherosclerosis. These risk factors, especially elevated LDL, should be treated aggressively. Caution should be used when considering agents that aggravate hyperglycemia.

A lipid panel should be performed annually (TC, LDL, HDL, TG). Consider direct LDL measurements, especially if TG >250 or if the specimen is to be obtained non-fasting. Elevated TC, LDL, TG and low HDL confer greater risk for atherosclerosis. Optimal LDL cholesterol levels for adults with diabetes are <100 . All patients with LDL >100 require medical nutrition therapy and other lifestyle modifications. Pharmacologic intervention is recommended if dietary interventions and lifestyle modifications are ineffective in lowering LDL to <100 .

Aspirin Therapy - Aspirin has been used as a primary and secondary prevention strategy to prevent cardiovascular events. Men and women with diabetes have a 2-4 fold increase in risk of dying from complications of cardiovascular disease (CVD). Aspirin in doses of 162-325 mg/day is recommended for patients with diabetes.

Strongly consider aspirin therapy as a primary prevention strategy in high risk men and women age 30 and above with diabetes. This includes individuals with family history of CVD, cigarette smoking, hypertension, obesity, albuminuria and dyslipidemia.

Use aspirin therapy as a secondary prevention strategy in diabetic men and women who have evidence of large vessel disease, such as history of MI, stroke, peripheral vascular disease, claudication or angina.

Eye Exam - Retinal exam through dilated pupils or fundus photo. Individuals with type 1 diabetes should receive an initial exam within 3-5 years of diagnosis once they are ≥ 10 years of age. People with type 2 diabetes should receive an exam at diagnosis, and yearly thereafter.

Dental Exam - Annual screen for periodontal disease and other oral pathology.

Foot Exam - Risk assessment to include pulse check and sensory evaluation with monofilament, identification of foot deformity, and documentation of history of foot ulcers.

Screen for Neuropathy - By history and physical; include sensory, motor and autonomic evaluation.

IHS Standards of Care for Patients with Type 2 Diabetes (continued)

4 -- Immunizations and Skin Tests

Flu Vaccine - Yearly

Pneumovax - Vaccinate everyone at the time of diagnosis. Revaccination should be strongly considered five (5) years after the first dose for those patients at highest risk of fatal pneumococcal infection (e.g., asplenic patients) or those at highest risk of rapid decline in antibody levels (e.g., those with chronic renal failure, nephrotic syndrome, or transplanted organs). Revaccinate all patients \geq age 65 years if it has been >5 years since initial vaccination.

Td - Every 10 years.

PPD - Once after diagnosis unless known positive. PPD-positive people with diabetes, including American Indians with Type 2 diabetes, have 5 times the risk of reactivating TB. All diabetic patients with positive PPD including those over age 35 should be given INH chemoprophylaxis according to current guidelines (see Section 9).

Hepatitis B - Vaccinate persons whose renal disease is likely to lead to dialysis or transplantation (serum creatinine ≥ 2.0).

5 -- Special Aspects of Diabetes

Care

Lab Tests - C-peptide, the other half of pro-insulin, can evaluate a patient's endogenous insulin secretion and help distinguish between Type 1 and Type 2 diabetes. The test can be useful in at least two clinical situations:

1. Solving a clinical problem about using oral agents vs. insulin.
2. Evaluating a patient with history of ketoacidosis when stable (useful in setting of ETOH, acidosis, and diabetes to determine ongoing need for insulin).

6 -- Self-Care Education

Use of the PCC education codes to document education is encouraged.

Nutrition Education - Meal planning, nutrition education, and exercise are the primary treatment strategies for Type 2 diabetes. The Indian Health Service Diabetes Program supports the American Diabetes Association position that all persons with diabetes receive regular nutrition counseling and are seen by an RD/nutritionist every six months to 1 year. Some people may require more frequent evaluation and counseling.

Diabetes Education - All patients with diabetes and their families should have diabetes self-care information. The National Standards for Diabetes Care and Patient Education provide guidelines for education program development with criteria specific for American Indian/Alaska Native health care facilities. Every facility should work towards providing systematic mechanisms to make culturally relevant self-care information available for patients.

IHS Standards of Care for Patients with Type 2 Diabetes (continued)

Exercise Education - Exercise is associated with improvement in both short- and long-term metabolic control. Exercise counseling should be provided to all persons with diabetes. The appropriate type of activity, including frequency, duration, and intensity, should be individualized for each patient.

Education and Glycemic Control

- Self monitoring results should be discussed with the patient at each visit.
- HbA1c results should be discussed with the patient within 2 weeks of the test, preferably at the patient visit.

Self-Blood Glucose Monitoring (SBGM)

- The purpose of SBGM is to determine the pattern of blood glucose throughout the day. This pattern provides information for selection and adjustments in therapy. Frequency of monitoring must be individualized and may vary as day-to-day circumstances require.

7 -- Routine Health Maintenance

Physical Exam – Complete exam as baseline, then routine.

Pap Smear/Pelvic Exam – Yearly

Breast Exam – Yearly

Mammogram – Every 1-2 years in women ages 40-49, yearly thereafter.

Rectal Exam/Stool Guaiac – Yearly in adults ≥ 40 years of age.

Tobacco Use – Current tobacco use should be documented and a referral made for cessation of tobacco use.

8 -- Pregnancy and Diabetes

All women who are in their childbearing years should receive pre-pregnancy counseling for optimizing metabolic control prior to conception. Counseling for family planning is essential to achieve this goal.

American Indian women are at increased risk for developing gestational diabetes (GDM), as are women with certain other risk factors, including but not limited to the following:

- previous gestational diabetes
- previous fetal macrosomia
- unexplained stillbirth
- congenital anomaly
- obesity
- insulin resistance syndrome
- polycystic ovarian syndrome (PCOS)
- family history of diabetes

These women should be screened for GDM early in pregnancy. If early screening is negative, the screen should be repeated after at 24-28 weeks gestation..

IHS Standards of Care for Patients with Type 2 Diabetes (continued)

8 -- Pregnancy and Diabetes (continued)

Women with GDM are at increased risk of developing type 2 diabetes (about one third of all AI/AN women with GDM will develop diabetes within 5 years). These women should be re-tested by OGTT at least 6-12 weeks post delivery to determine their glyce-mic status. Women with a normal postpartum OGTT should be re-tested every 1-3 years. Bear in mind that diagnostic standards for diabetes in breastfeeding women have not been established. Blood glucose should be monitored in the postpartum and lactating period, including regular self blood glucose testing, as clinically appropriate.

All women with a history of GDM should receive counseling/education regarding lifestyle modifications that will reduce or delay the development of type 2 diabetes. Moreover, the importance of maintaining optimal glucose control prior to and during any subsequent pregnancy should be stressed. Mothers should be made aware that children of GDM pregnancies should be monitored for obesity and abnormalities of glucose utilization. Further recommendations and guidelines for the screening, diagnosis and treatment of GDM may be found in the most recent *Clinical Practice Recommendations* of the American Diabetes Association (published annually) and Metzger BE, Coustan DR (Eds.): *Proceedings of the Fourth International Workshop-Conference on Gestational Diabetes Mellitus*. Diabetes Care 21 (Suppl. 2): B1-B167, 1998.

9 -- Tuberculosis and Diabetes Patients*

A “positive” PPD skin test (i.e., ≥ 10 mm induration 48-72 hours after administration) means that a person either has latent tuberculosis infection (LTBI) or active tuberculosis (TB) disease. Active TB disease needs to be ruled out prior to starting patients with LTBI on treatment. Treatment for active TB and LTBI are different*.

Patients with diabetes and LTBI are at high risk of progressing to active TB, if they are not treated for LTBI. Studies have shown that the risk is 2 to 6 times greater than in patients without diabetes. Other factors that further increase the risk for TB include: recent PPD conversion within 2 years, intravenous drug use, chest film showing prior active disease that was never treated, immunosuppressive drugs, and ESRD. Cutaneous anergy increases as patients age and develop complications of diabetes such as ESRD. Anergy may lead to false negative PPD test results.

In most cases progression of LTBI to active TB can be prevented by treatment with INH. In general, patients with diabetes who have a positive PPD (accurately read by a provider trained in interpretation of PPD) should

IHS Standards of Care for Patients with Type 2 Diabetes (continued)

9 -- Tuberculosis and Diabetes Patients* (continued)

receive treatment for LTBI, *except* in the following circumstances:

- severe liver disease
- suicidal ideation
- adverse reaction to INH.

Patients receiving treatment for LTBI should be followed and monitored for potential hepatotoxicity. While national recommendations emphasize monitoring hepatotoxicity through systematic repetitive patient education and clinical evaluation for signs and symptoms of hepatotoxicity, baseline measurement of liver function tests and after one month should be considered, especially in patients receiving other potentially hepatotoxic medications. Some experts recommend that INH be discontinued if transaminase levels exceed three times the upper limit of normal when associated with symptoms or five times the upper limit of normal if the patient is asymptomatic.

*Recommendations for targeted tuberculin testing and treatment of LTBI in MMWR, June 09, 2000/ 49(RR06); 1-54 or at: www.cdc.gov/mmwr/indrr_2000.html Or at: Treatment for active TB disease is detailed in: CDC Core Curriculum in TB: What the Clinician Should Know. CDC, 2000 (4th edition).

IHS TB Protocol for Patients with Diabetes:

- **Check the PPD status** of all patients with diabetes.
- **If the PPD status is negative or unknown:**
 - PPD testing should be done within one year of initial work up for diabetes diagnoses, and treated if they have LTBI.
 - If no PPD has been *placed* since the diagnosis of diabetes, and the patient's PPD status is negative or unknown, a PPD status needs to be ascertained.
 - Subsequent PPD testing is done only if there is contact with an active TB case.

- **If the PPD status is positive:**

- Check for completion of past treatment for active TB or LTBI (6-9 months of INH for LTBI or multiple drug therapy for active disease).
- If the patient has not been adequately treated, search for active disease by history (weight loss, etc), fever (record temperature) and recent chest x-ray (within 6 months). If there is no evidence of active disease, recommend treatment for LTBI (9 mos. of INH 300 mg daily) to all patients with diabetes, regardless of age, unless the patient has liver disease, suicide ideation or a previous adverse reaction to INH. Patients with diabetes should be given pyridoxine (10 -50 mg/day) with their INH. Consider directly observed therapy of LTBI when possible, especially for patients on dialysis.

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